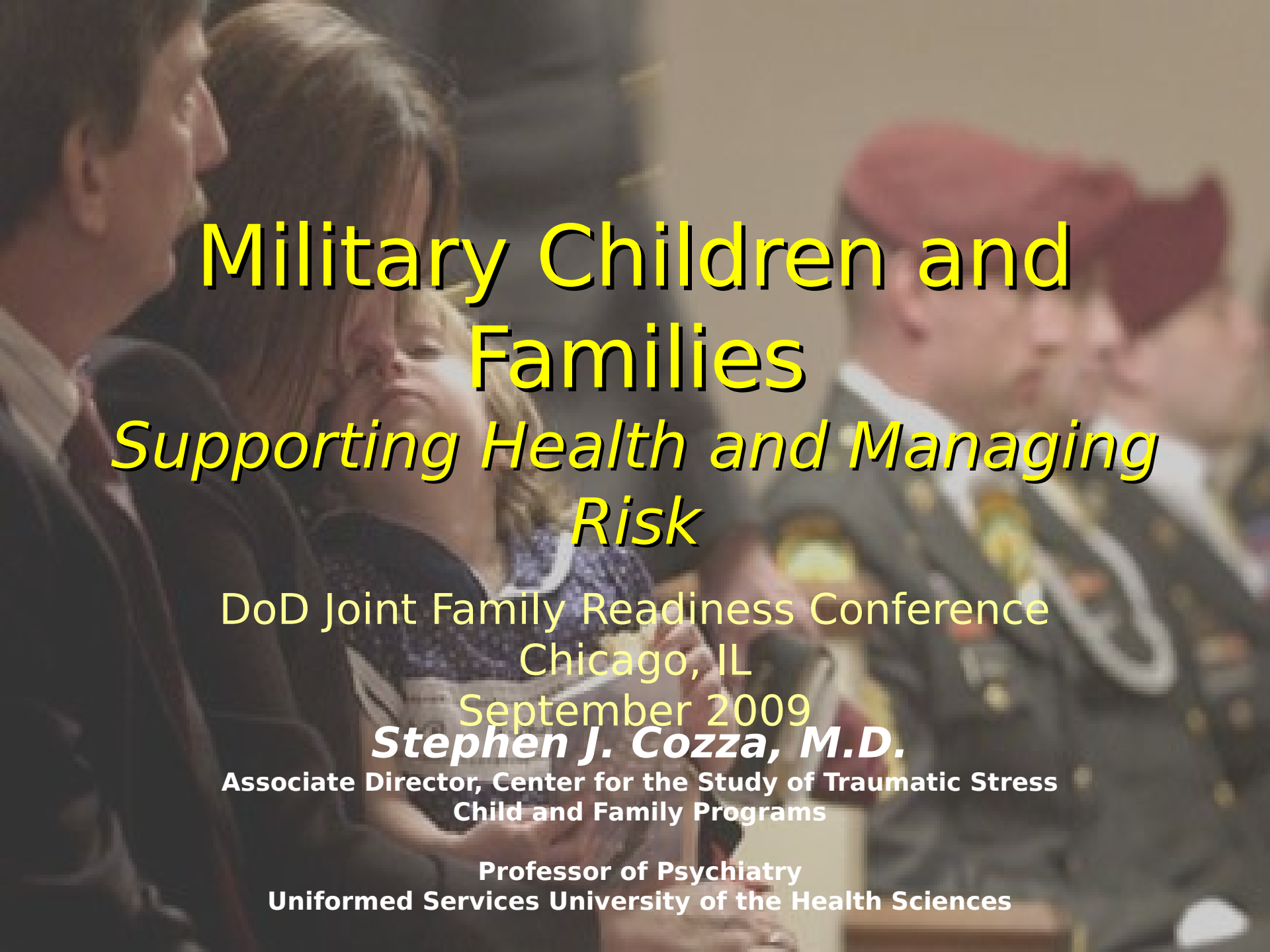


Military Children and Families

Supporting Health and Managing Risk

DoD Joint Family Readiness Conference
Chicago, IL
September 2009

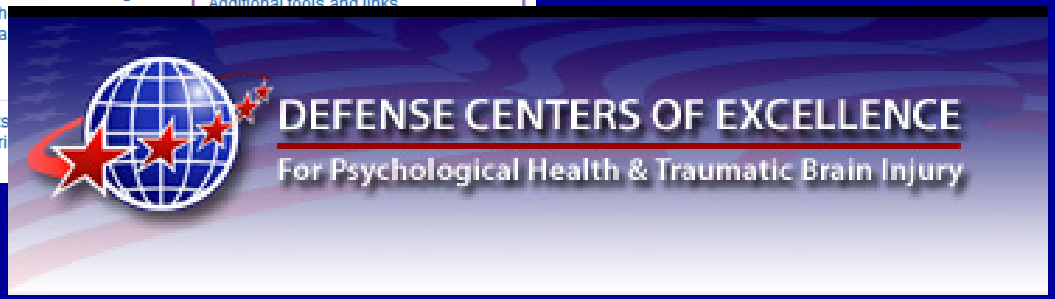
Stephen J. Cozza, M.D.
Associate Director, Center for the Study of Traumatic Stress
Child and Family Programs

Professor of Psychiatry
Uniformed Services University of the Health Sciences

Collaborating Center NCTSN and DCoE

NCTSN
The National Child Traumatic Stress Network
Home
CTS Intro
Trauma Types
Resources
En Español
About Us
Products
Search
Welcome to
NCTSN.org
The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.
Are you in crisis?
Does someone you know need help?
Click here
Child Traumatic Stress (CTS) Introduction
What causes child traumatic stress? How does it affect a child? What can be done about it?
For Parents and Caregivers
available.
Military Children and Families
Care of our nation's military children helps sustain our fighting force. Gathered here are resources about
for caregivers, service providers, and
For Educators
What are the effects of trauma on schools and learning?
do to help? How can they respond to a
For the Media
press releases, and find tips for
Public Awareness
National Preparedness Month (September 2008)
September 11 Anniversary
It's hurricane season!
Be prepared
Tips for parents and teachers to aid children's recovery

www.nctsn.org



www.dcoe.health.mil

FACT SHEET FOR PROVIDERS

Center for the Study of Traumatic Stress

Understanding the Effects of Trauma and Traumatic Events to Help Prevent, Mitigate and Foster Recovery for Individuals, Organizations and Communities

A Program of Uniformed Services University, Our Nation's Federal Medical School, Bethesda, Maryland • www. usuhs.mil/csts/

POST DEPLOYMENT HEALTH AND DISTRESS RESPONSES

Overview for Practitioners

As the Global War on Terror continues, more service members will be exposed or re-exposed to combat experiences. This exposure will affect them as well as countless military spouses, children, parents, siblings, and friends of the deployed.

Studies of service members returning from Iraq and Afghanistan show that the vast majority

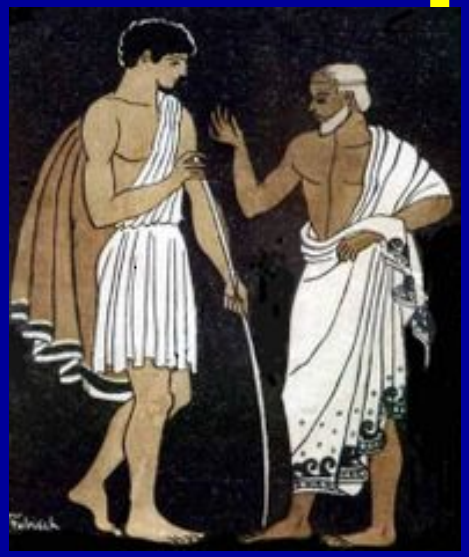
...up to 20% of returning service members are likely to continue to endorse symptoms that are consistent with emotional problems such as post traumatic stress disorder (PTSD) or depression.

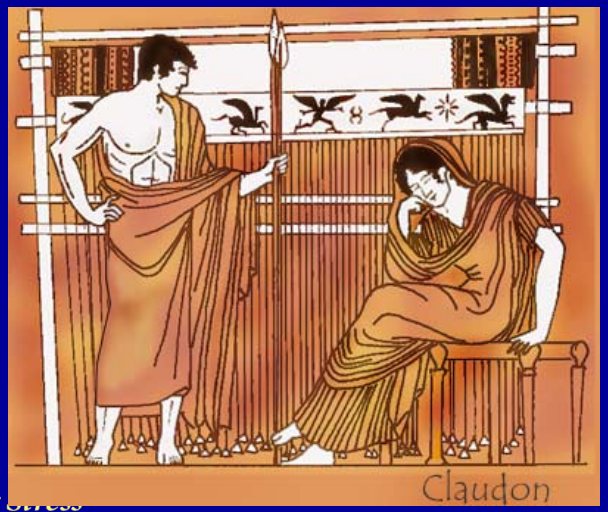
to two months after returning home, medical attention is important.

- *Insomnia* — Difficulty in falling asleep, sustaining sleep, or awakening early from sleep.
- *Motor restlessness* — Jitteriness, fidgety movement, or an abundance of nervous energy.

http://www.cstsonline.org

Homer's Odyssey and the Military Family





Our Military Community

Large military dependent population

44% AD SMs have children

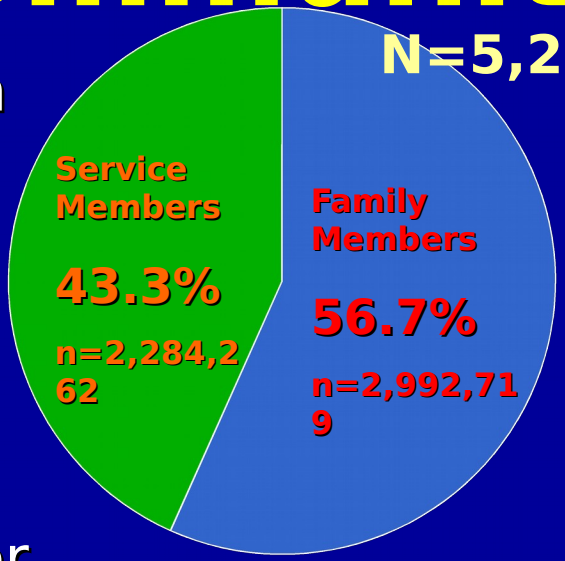
Two-thirds of children 11 and under

Forty percent of children 5 and under

Military children are our nation's children

Military children are our future

Concept of military family relatively new



The Recovery and Social Environment

Military service member is contained within layers of support systems

Transactional interplay between layers

Interaction may be mutually helpful or disruptive

Family is the closest social support

Health of family and service\ member is interrelated

Military Deployments

- Traditional Model: Stages of Deployment
  - pre-deployment, deployment, sustainment, redeployment, post-deployment (Pincus et al, 2001)
- Multiple and Recurrent Deployments
- Shift from occasional events to continuous
- Complicated deployments (parental illness, injury or death)
- Requires change to model of sustainment to support communities, families and individuals under stress

Military Family Challenges

Deployment

*transient stress

*modify family roles/function

*temporary accommodation

*reunion adjustment

*military commun maintained

*probable sense of growth and accomplishmt

Multiple Deployments ?

Injury

*trans or perm stress

*modify family roles/function

*temp or perm accommodation

*injury adjustment

*military commun jeopardized

*change must be integrated before growth

Psych Illness

*trans or perm stress

*modify family roles/function

*temp or perm accommodation

*illness adjustment

*military commun jeopardized

*change must be integrated before growth

Death

*perm stress

*modify family roles/function

*permanent accommodation

*grief adjustment

*military commun jeop or lost

*death must be grieved before growth

Complicated Deployment

STRESS LEVEL

Corrosive Impact of Stress

- ***Multiple deployments during wartime***
- Distraction of responsible parties
  - many contingencies to address
  - manage anxiety and personal stress
  - potential impairment of role functioning
- Disruption of relationships, interpersonal strife, loss of attachments
- Most dependent are most vulnerable in the process
- Reduction of Parental Efficacy – the availability and effectiveness of the service member and spouse
- Impact on Community Efficacy – leaders and service providers

Child Maltreatment and Deployment

- **Rentz ED, Marshall SW, Loomis D, et al.,** Am J Epidem 2007
  - Time series analysis of Texas child maltreatment data in military and nonmilitary families from 2000-2003

- **Gibbs DA, Martin SL, Kupper LL, et al.,** J Amer Med Assoc 2007
  - Descriptive case series of 1771 Army families with substantiated child maltreatment

- **McCarroll JE, Fan Z, Newby JH, et al.,** Child Abuse Rev 2008
  - Tabulation of Army Central Registry 1990 – 2004

  - Elevated rates of child maltreatment during combat deployment periods
  - Greatest rise in maltreatment appears to be attributed to child neglect
  - Rates of child neglect appear highest in junior enlisted population

2008 DoD Survey of Active Duty Spouses

- Survey of 13,000 military spouses across services in spring/summer 2008
- Spouses reported the following changes in their children as a result of the most recent deployment:
  - Increased levels of fear/anxiety (60%)
  - Increased behavior problems at home (57%)
  - Increased closeness to family members (47%)
  - Decreased academic performance (36%)
  - Increased problem behaviors at school (36%)
- Just over half (53 percent) of spouses felt that their children have coped well or very well. However, nearly a quarter (23 percent) felt that their children coped poorly or very poorly.

Reports of Mental Health Utilization Data (2003-2008)

- Increased utilization of inpatient mental health services, particularly in children and spouses
- Rates of utilization of outpatient mental health services has increased for children and spouses
- Some differences in type of utilization (younger children, more outpt; older child/teen, more inpt)
- Mainly provided in the civilian sector
- ***Danger in over-interpreting utilization data***
  - ***many variables, increased access, changes in qualification criteria***

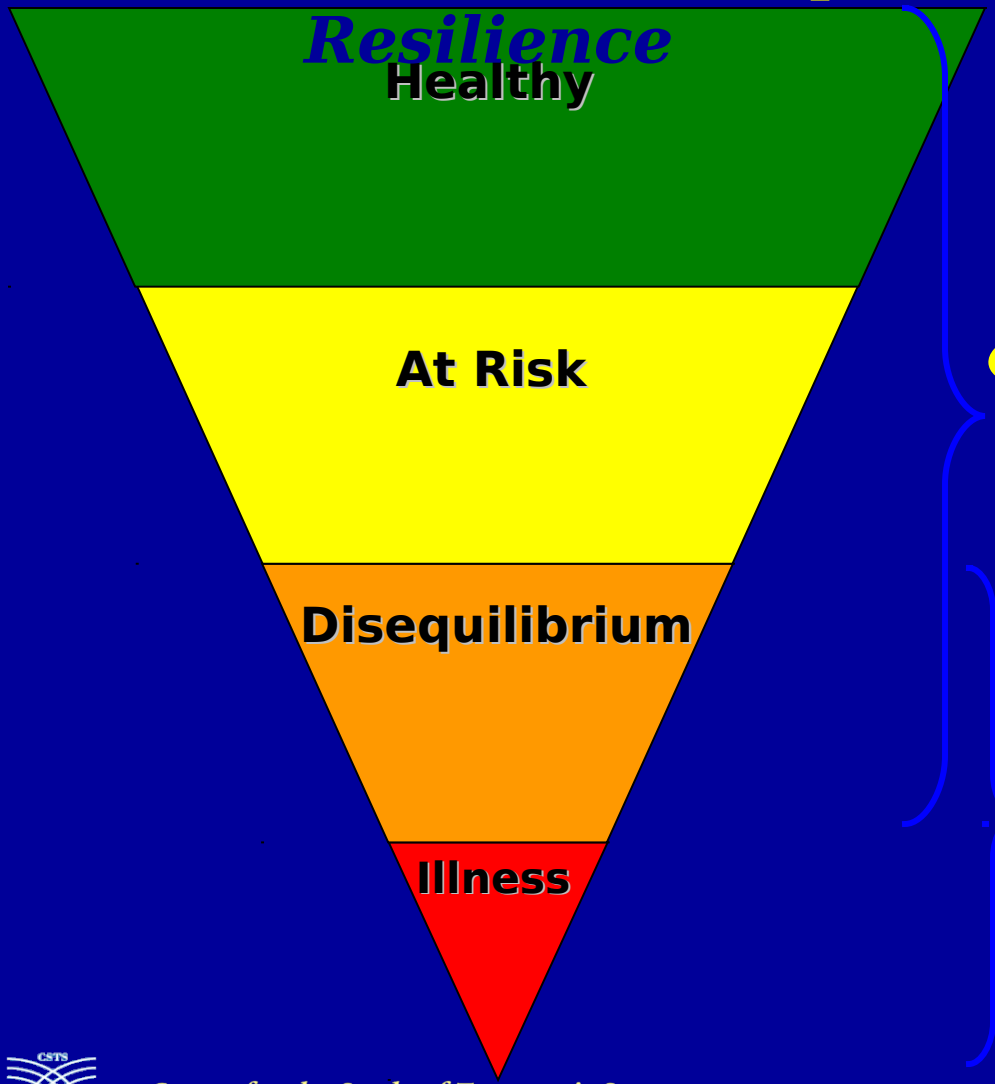
OIF and OEF Military Deployment Literature

- Studies have focused on children of varying ages pre-school (Chartrand et al, 2008) through school age and teens (Chandra, et al 2008, Huebner & Mancini, 2005, Huebner et al, 2008)
- No identified studies of impact on infants and toddlers
- Most studies evidence distress in children at all ages
- Evidence of anxiety, depression as well as behavioral disturbances
- Teens demonstrated resilience and maturity (Huebner & Mancini, 2005)

Military Children – What Science Tells Us

- literature is limited, fewer combat exposed samples
- health of military children when compared to civilian counterparts - child and family strength
- elevated distress/symptoms in deployed families
- must differentiate and assess groups with risk factors based upon experience
    - (single parents, dual military parents, multiple combat deployments, injury, parental illness, death) and developmental level
- need to identify mediating factors that contribute to child and family risk or health
- need to examine differences at different ages
- longitudinal study needed to determine the course of distress resolution and developmental outcome

Range of Functional Responses



Community Support
- Command Actions
- Support services
- Education
- Self-help services

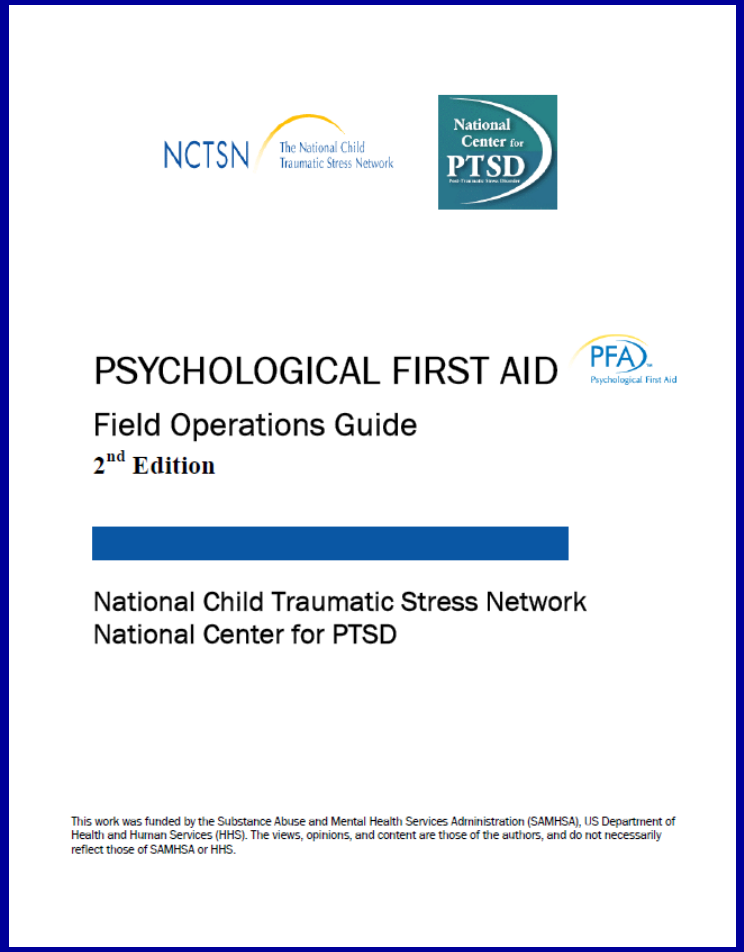
Mental Health Support
- Clinical Treatment
- Psychoeducation
- Skill Building
- Communication

Avoid complicating factors

Support toward Resilience

Center for the Study of Traumatic Stress

Psychological First Aid (PFA)


NCTSN
The National Child Traumatic Stress Network
National Center for PTSD
PSYCHOLOGICAL FIRST AID
PFA
Psychological First Aid
Field Operations Guide
2nd Edition
National Child Traumatic Stress Network
National Center for PTSD
This work was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, opinions, and content are those of the authors, and do not necessarily reflect those of SAMHSA or HHS.

- **establishing safety**
- **promoting calm through distress reduction**
- **building a sense of self and community efficacy**
- **fostering connectedness**
- **promoting a sense of hope**

(Hobfall et al, 2007)

PFA – Supporting Health/Managing Risk

	Safety	Calming	Self-efficacy	Connect	Hope
Infants and Toddlers (0-3 years)	Parenting Child Care Maltreatment**	Parenting Child Care Parent Dep**	Parental efficacy *behavioral activation*	Family Connected	Parental Hope
Preschoolers (3-5 years)	Parenting Child Care Maltreatment**	Cognitive Distort Magical Think**	Developing child efficacy *behavioral activation*	Family Connected	Parental Hope
School Age (5-12 years)	Parenting	Worry/Doubt**	Sense of Mission Activated Goals *behavioral activation*	Peer Relationships School Connections Sports/Activities Coaches/teachers	Future directed *Sense of meaning*
Teens (13-18 years)	Risk Behav** Subst Use**	Worry/Doubt**	Sense of Mission Maintain direction *behavioral activation*	Peer Relationships Independent but connected**	Future directed *Sense of meaning*

Identifying Risk and Illness

Potential Risk Factors

- Younger children and boys
- Pre-existing psychiatric or developmental problems
- Non-deployed spouses that exhibit higher distress or poorer function
- Higher exposure (multiple deployments, single parent or dual parent deployments, complicated deployments)
- Lack of social/resource connectedness (NG, reserves, language barriers, off-installation housing, few friends/family available)
- Family and parenting risk factors (parental anger, disconnection, marital conflict, poor financial support)

Unique Challenges in Theatre

Psychiatric and Behavioral Responses to War and Combat

- Change in Sleep
- Decrease in feeling Safe
- Isolation (staying at home)

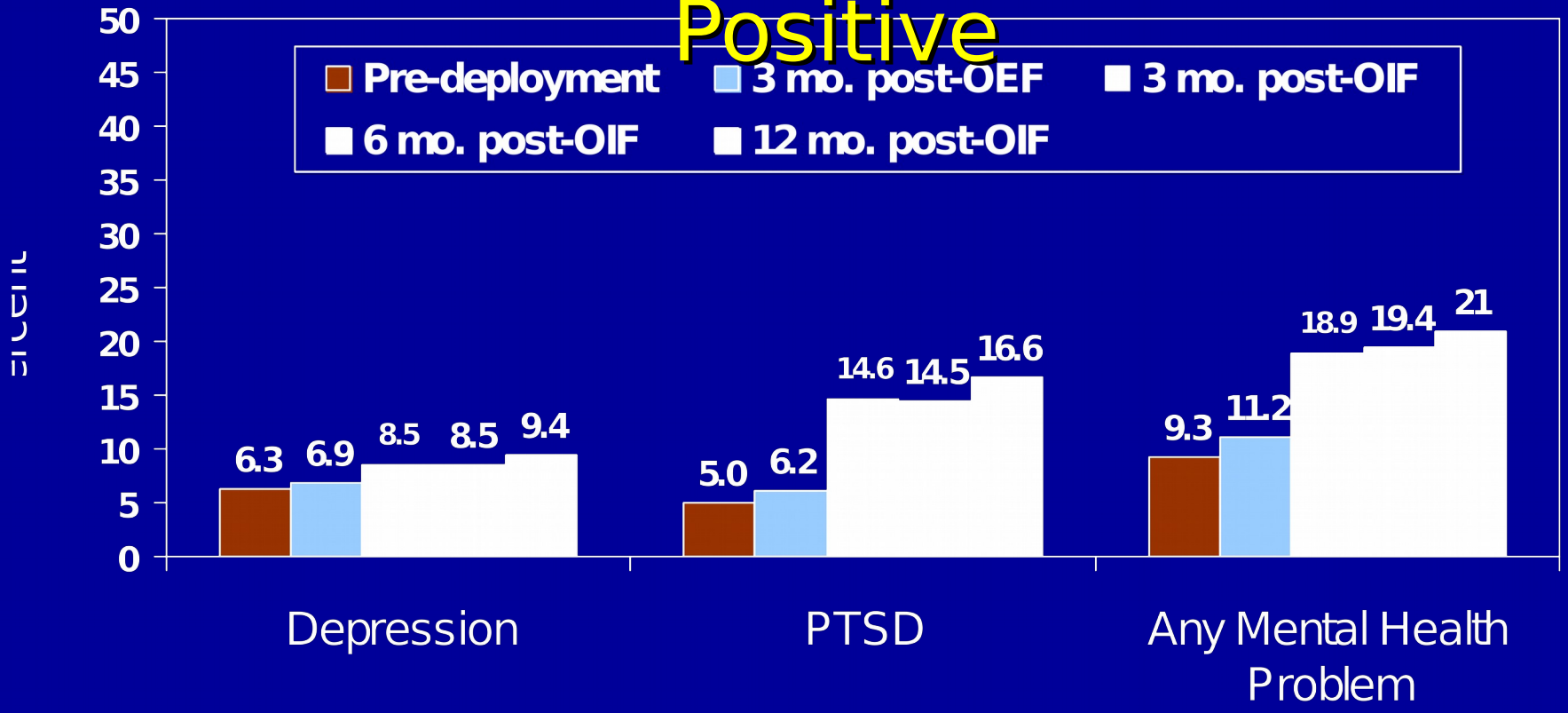
- Resilience
- Anxiety
- PTSD
- Depression
- Substance use disorders

- Smoking
- Alcohol
- Reckless drivi

Impact of Combat Exposure on Service Members

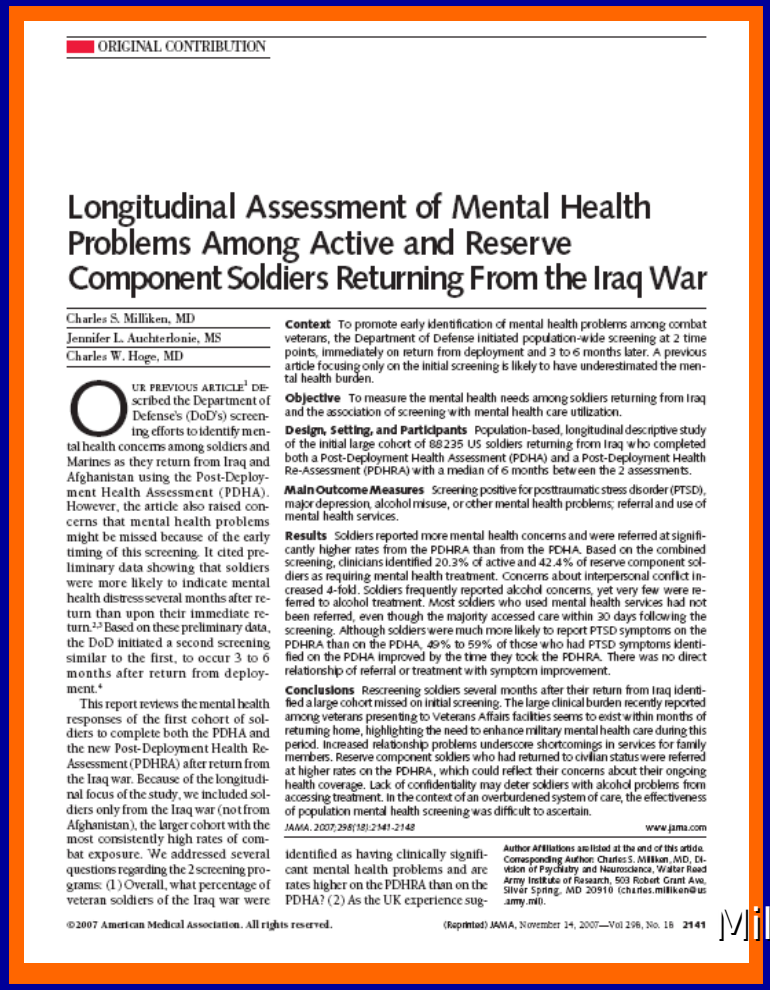
- high level of traumatic combat exposures (witnessing injury or death, exposure to dead bodies, hand-to-hand combat, blast injuries) Hoge et al. 2004
- resultant psychiatric sequelae and other morbidity (depression, PTSD, substance use disorders, cognitive disorders, physical injury) Hoge et al, 2004; Grieger et al, 2006, Milliken et al, 2007; Tanielian & Jaycox, 2008

Percent of Soldiers Screening Positive



- From WRAIR Land Combat Study and NEJM July 2004 Hoge, et.al.

Post-Deployment Health Re-Assessment (PDHRA) Results



ORIGINAL CONTRIBUTION

Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War

Charles S. Milliken, MD
Jennifer L. Auchterlonie, MS
Charles W. Hoge, MD

Context To promote early identification of mental health problems among combat veterans, the Department of Defense initiated population-wide screening at 2 time points, immediately on return from deployment and 3 to 6 months later. A previous article focusing only on the initial screening is likely to have underestimated the mental health burden.

Objective To measure the mental health needs among soldiers returning from Iraq and the association of screening with mental health care utilization.

Design, Setting, and Participants Population-based, longitudinal descriptive study of the initial large cohort of 88235 US soldiers returning from Iraq who completed both a Post-Deployment Health Assessment (PDHA) and a Post-Deployment Health Re-Assessment (PDHRA) with a median of 6 months between the 2 assessments.

Main Outcome Measures Screening positive for posttraumatic stress disorder (PTSD), major depression, alcohol misuse, or other mental health problems; referral and use of mental health services.

Results Soldiers reported more mental health concerns and were referred at significantly higher rates from the PDHRA than from the PDHA. Based on the combined screening, clinicians identified 20.3% of active and 42.4% of reserve component soldiers as requiring mental health treatment. Concerns about interpersonal conflict increased 4-fold. Soldiers frequently reported alcohol concerns, yet very few were referred to alcohol treatment. Most soldiers who used mental health services had not been referred, even though the majority accessed care within 30 days following the screening. Although soldiers were much more likely to report PTSD symptoms on the PDHRA than on the PDHA, 49% to 59% of those who had PTSD symptoms identified on the PDHA improved by the time they took the PDHRA. There was no direct relationship of referral or treatment with symptom improvement.

Conclusions Rescreening soldiers several months after their return from Iraq identified a large cohort missed on initial screening. The large clinical burden recently reported among veterans presenting to Veterans Affairs facilities seems to exist within months of returning home, highlighting the need to enhance military mental health care during this period. Increased relationship problems underscore shortcomings in services for family members. Reserve component soldiers who had returned to civilian status were referred at higher rates on the PDHRA, which could reflect their concerns about their ongoing health coverage. Lack of confidentiality may deter soldiers with alcohol problems from accessing treatment. In the context of an overburdened system of care, the effectiveness of population mental health screening was difficult to ascertain.

JAMA. 2007;298(18):2141-2148 www.jama.com

Our previous article[1] described the Department of Defense's (DoD's) screening efforts to identify mental health concerns among soldiers and Marines as they return from Iraq and Afghanistan using the Post-Deployment Health Assessment (PDHA). However, the article also raised concerns that mental health problems might be missed because of the early timing of this screening. It cited preliminary data showing that soldiers were more likely to indicate mental health distress several months after return than upon their immediate return.[2,3] Based on these preliminary data, the DoD initiated a second screening similar to the first, to occur 3 to 6 months after return from deployment.[4]

This report reviews the mental health responses of the first cohort of soldiers to complete both the PDHA and the new Post-Deployment Health Re-Assessment (PDHRA) after return from the Iraq war. Because of the longitudinal focus of the study, we included soldiers only from the Iraq war (not from Afghanistan), the larger cohort with the most consistently high rates of combat exposure. We addressed several questions regarding the 2 screening programs: (1) Overall, what percentage of veteran soldiers of the Iraq war were identified as having clinically significant mental health problems and are rates higher on the PDHRA than on the PDHA? (2) As the UK experience sug-

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- Sampled over 88,000 SMs
- Elevated rates of positive screening of PDHRA compared to PDHA
- Over 40% of combat veteran reserve and NG component referred to mental health
- Variability in persistence of PTSD symptoms between PDHA and PDHRA
- ***Four fold increase in veteran concerns related to interpersonal conflict***
- Problems with mental health service access for non-active and family members

Milliken, et al. JAMA 2007

IMPACT OF PARENTAL PSYCHIATRIC ILLNESS ON MILITARY CHILDREN

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 1, 2004 VOL. 351 NO. 1

Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care

Charles W. Hoge, M.D., Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D., Dennis McGurk, Ph.D., Dave I. Cotting, Ph.D., and Robert L. Koffman, M.D., M.P.H.

ABSTRACT

BACKGROUND
The current combat operations in Iraq and Afghanistan have involved U.S. military personnel in major ground combat and hazardous security duty. Studies are needed to systematically assess the mental health of members of the armed services who have participated in these operations and to inform policy with regard to the optimal delivery of mental health care to returning veterans.

METHODS
We studied members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq (n=2530) or three to four months after their return from combat duty in Iraq or Afghanistan (n=3671). The outcomes included major depression, generalized anxiety, and post-traumatic stress disorder (PTSD), which were evaluated on the basis of standardized, self-administered screening instruments.

RESULTS
Exposure to combat was significantly greater among those who were deployed to Iraq than among those deployed to Afghanistan. The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6 to 17.1 percent) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent); the largest difference was in the rate of PTSD. Of those whose responses were positive for a mental disorder, only 23 to 40 percent sought mental health care. Those whose responses were positive for a mental disorder were twice as likely as those whose responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care.

CONCLUSIONS
This study provides an initial look at the mental health of members of the Army and the Marine Corps who were involved in combat operations in Iraq and Afghanistan. Our findings indicate that among the study groups there was a significant risk of mental health problems and that the subjects reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.

From the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, U.S. Army Medical Research and Materiel Command, Silver Spring, Md. (C.W.H., C.A.C., S.C.M., D.M., D.I.C.); and First Naval Construction Division, Norfolk, Va. (R.L.K.). Address reprint requests to Dr. Hoge at the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, 503 Robert Grant Ave., Silver Spring, MD 20910, or at charles.hoge@na.amedd.army.mil.

N Engl J Med 2004;351:13-22.
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- Parental psychiatric illness
  - disrupts parental role
    - permissive parenting
    - negative/hostile engagements
    - reduction in positive parenting
  - disrupts child development
  - child confusion and cognitive distortion
  - increases risk behaviors
    - possible domestic violence
    - substance misuse
- PTSD
  - Avoidance – withdrawal of parental availability
  - numbing

Transgenerational Effects of PTSD In Vietnam Vet relationships/families

- Vietnam veteran families with PTSD evidence severe and diffuse problems in marital and family adjustment, parenting and violent behavior (Jordan et al .1992)
- Broad relationship problems/difficulty with intimacy correlated with severity of PTSD symptoms (Riggs et al. 1998)
- PTSD adversely effects interpersonal relationships, family functioning and dyadic adjustment (MacDonald et al. 1999)

Family Impact of PTSD in Vietnam Vets Mediating Factors

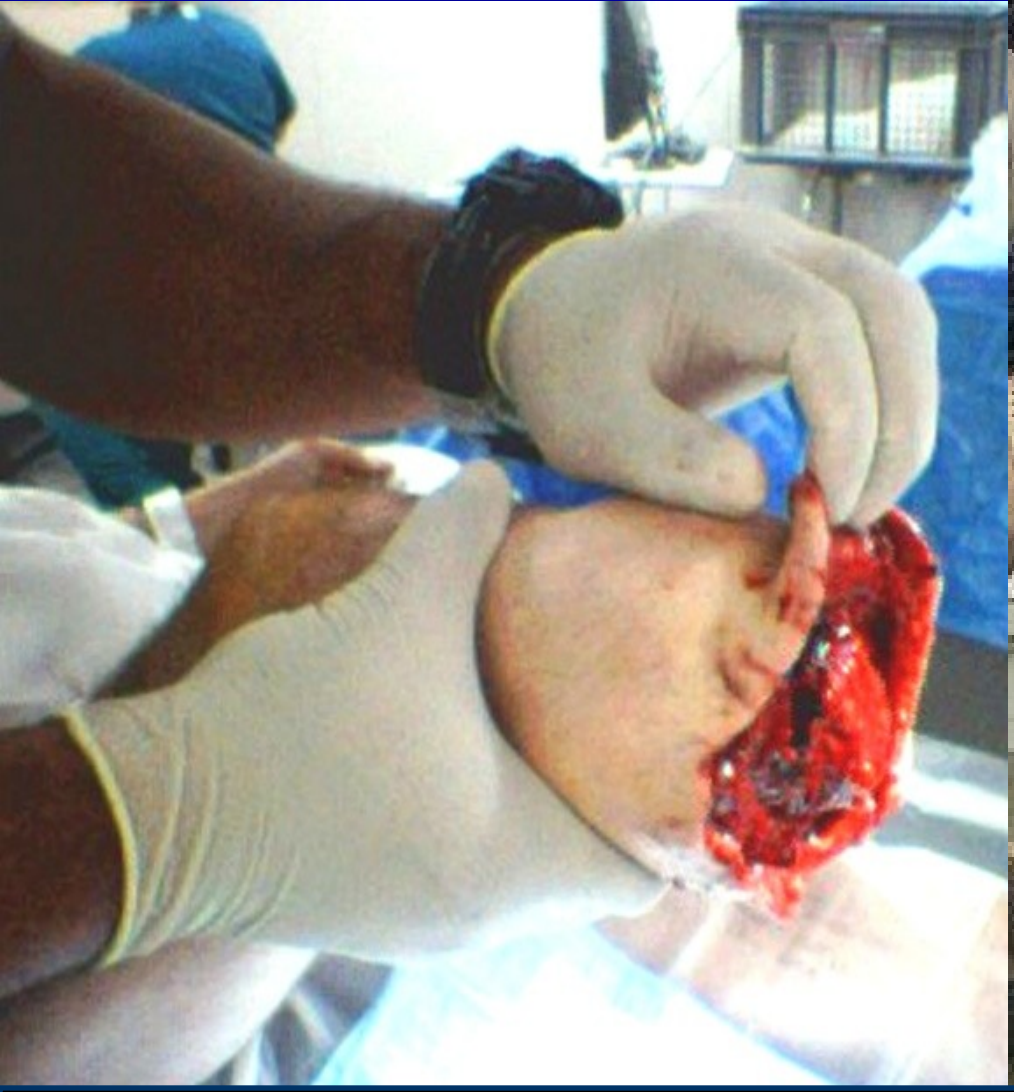
- *emotional numbing/avoidance* may be component of PTSD most closely linked to interpersonal impairment in relationship with partners and children (Ruscio et al. 2002, Galovski & Lyons 2004)
- Co-morbid *veteran anger and depression* as well as *partner anger* also mediate problems in Vietnam Vet families with PTSD (Evans et al. 2003)

Family Problems Among Recently Returned Military Veterans

- Sayers et al, 2009
- GWOT combat veterans referred to mental health
- Three fourths of married/cohabitating veterans reported family problem in past week
  - Feeling like guest in household (40.7%)
  - Children acting afraid or not being warm (25.0%)
  - Unsure about family role (37.2%)
- Veterans with depression or PTSD had increased problems

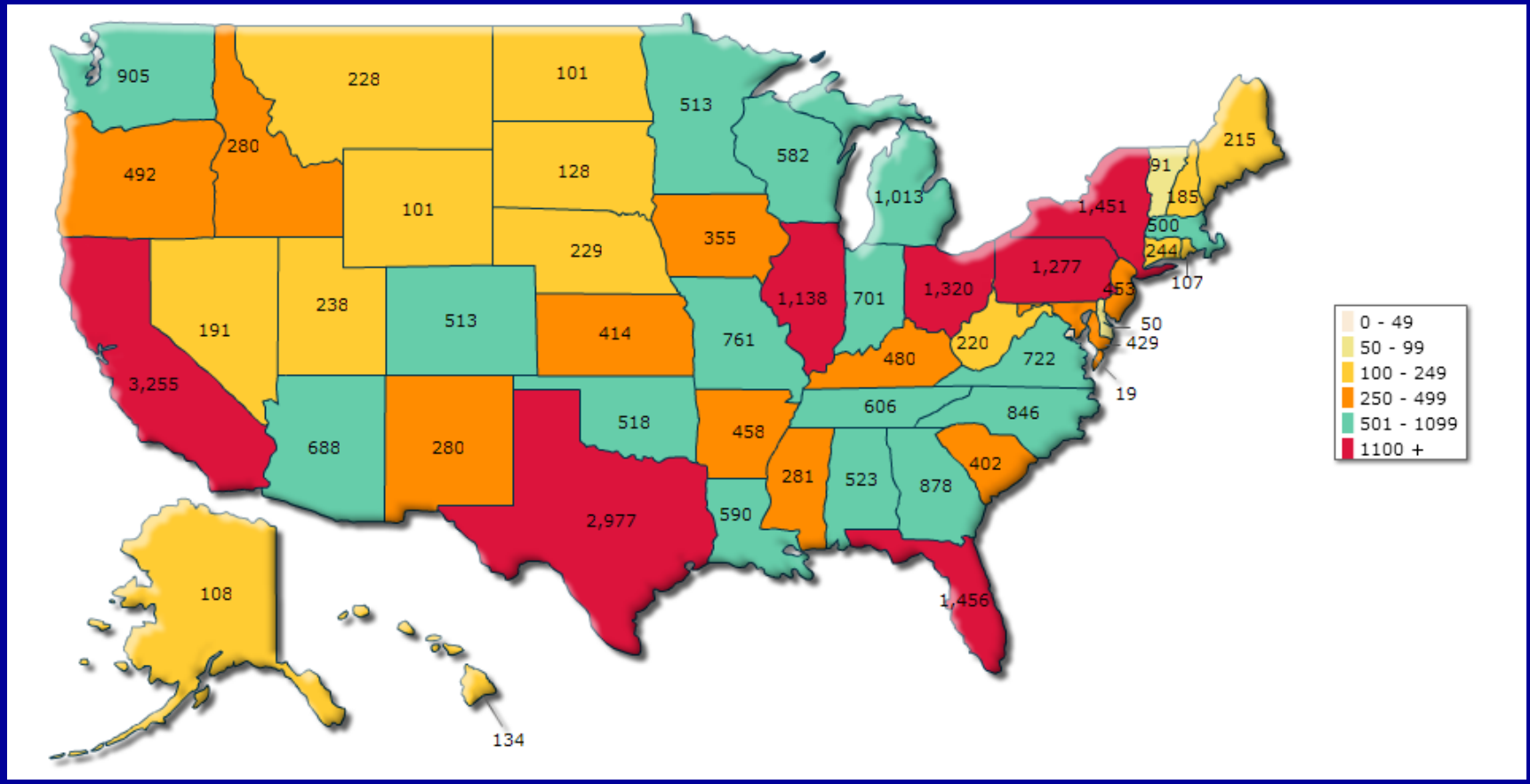
Adult Mental Health Providers

- Become familiar with the members of your client's family
- Become interested in the functional impact of the illness on marriages and parenting
- Listen for signs and symptoms that children are having difficulty and may need intervention of their own
- Be aware of preexisting psychiatric or developmental problems in children of service members that might place them at risk for greater problems
- Remember the longitudinal course and progression of family relationship difficulties may worsen.
- With a patient's permission, consider inviting other family members to a clinical session to the discuss nature of family relationships.



Impact of Combat Injuries

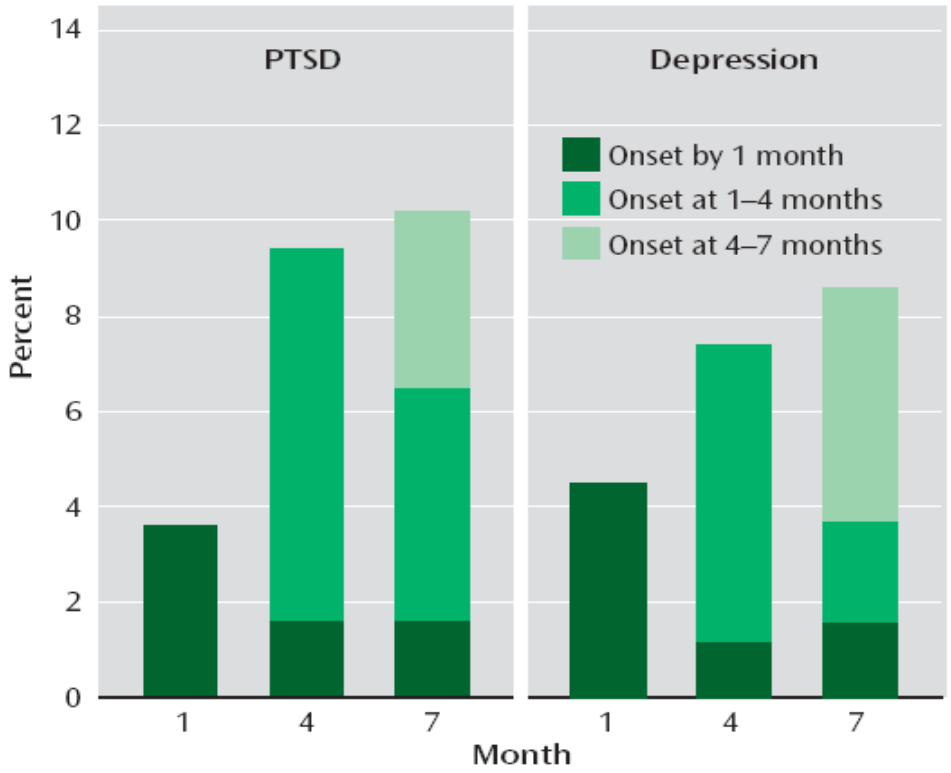
Combat Injured Service Members



Reported 2 FEB 2009
source: http://www.icasualties.org/oif/

Posttraumatic Stress Disorder and Depression in Battle-Injured Soldiers

FIGURE 1. Rates of PTSD and Depression at 1, 4, and 7 Months Among 243 U.S. Soldiers With Serious Combat Injuries Who Completed All Three Assessments



GRIEGER, COZZA, URSANO, ET AL *Am J Psychiatry 163:10, October 2006*

Impact of Parental Combat Injury on Children

- Little information on the impact on children due to injury of parent during wartime
- May extrapolate from studies done in other injured/ill parent populations
- Unique child responses based upon parental illness are expected
- Parental psychiatric illness also impacts negatively on children

Impact of Parental Combat Injury on Children

Impact of parental brain trauma on children

(Urbach and Culbert 1991)

- Dealing with changed parent
- Dealing with disfigurement of parent
- Changed home circumstances

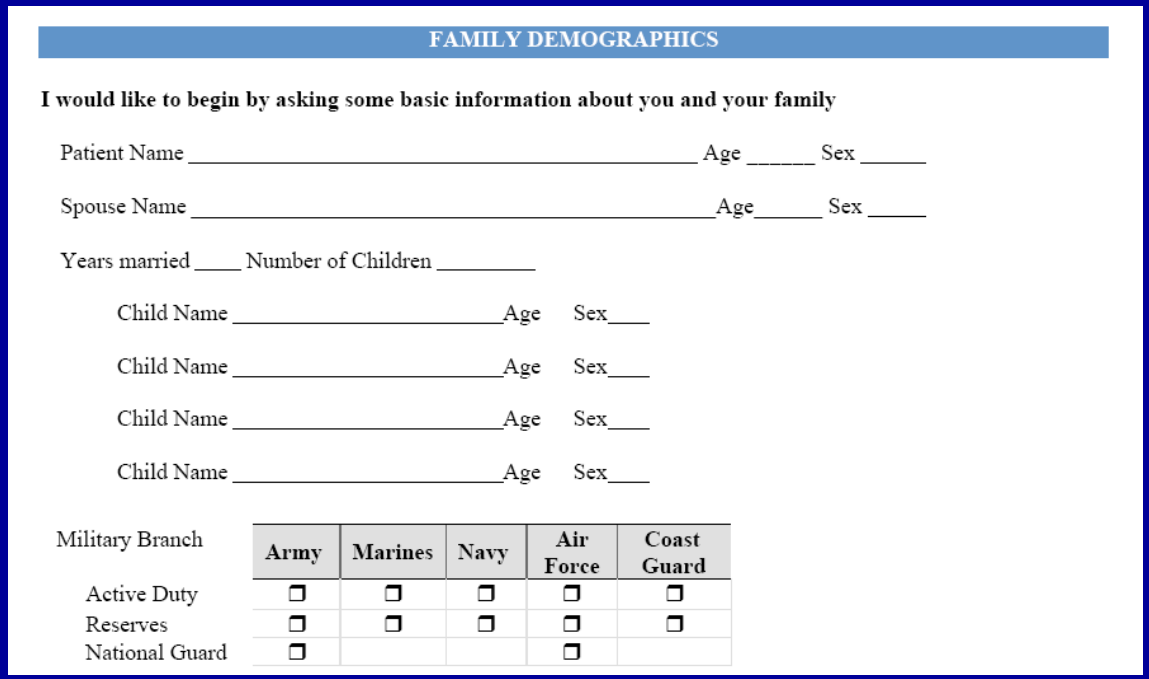
Impact of parental brain trauma on children

(Pessar et al, 1993)

- Family burden: trigger to family violence and family disintegration
- Noticeable behavior changes in parent
  - Poor anger control
  - Poor impulse control
  - Use of threats, bullying and other child maltreatment
- Changes in children's behaviors and emotions
  - Oppositional/angry

Parent Guidance Assessment
Combat Injury (PGA-CI)

- semi-structured clinical interview
- assist in data collection for family assistance strategies
- not for self-administration
- to be used by skilled clinicians



FAMILY DEMOGRAPHICS

I would like to begin by asking some basic information about you and your family

Patient Name _____ Age _____ Sex _____

Spouse Name _____ Age _____ Sex _____

Years married ____ Number of Children _____

Child Name _____ Age Sex____

Child Name _____ Age Sex____

Child Name _____ Age Sex____

Child Name _____ Age Sex____

Military Branch	Army	Marines	Navy	Air Force	Coast Guard
Active Duty	❒	❒	❒	❒	❒
Reserves	❒	❒	❒	❒	❒
National Guard	❒			❒	

UNIFORMED SERVICES UNIVERSITY
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Assessment of Concerns and Needs of Families Following Combat Injury

PGA-CI record review analysis

Stephen J. Cozza, M.D.*, Ryo S. Chun, M.D.**, Teresa L. Arata-Maiers, Psy.D.***, Jennifer Guimond, Ph.D.*, Brett Schneider, M.D.**

* Center for the Study of Traumatic Stress, Uniformed Services University, Bethesda, MD, ** Walter Reed Army Medical Center, Washington, D.C., *** Brooke Army Medical Center, San Antonio, TX

Preliminary Data
Not for Distribution

Sample Description

N = 41 Families

- 29 from WRAMC
- 12 from BAMC

Data based on spouse report

Family Disruption

- 80% reported moderate to severe impact on living arrangements
- 78% reported moderate to severe impact on child and family schedules
- 86% reported spending less time with children
- 48% reported moderate to severe impact on discipline

Injury Communication

Dialogue about the injury and its consequences within and outside of family.

Respecting the high emotional valence of injury-related topics (incorporating principles of risk communication)

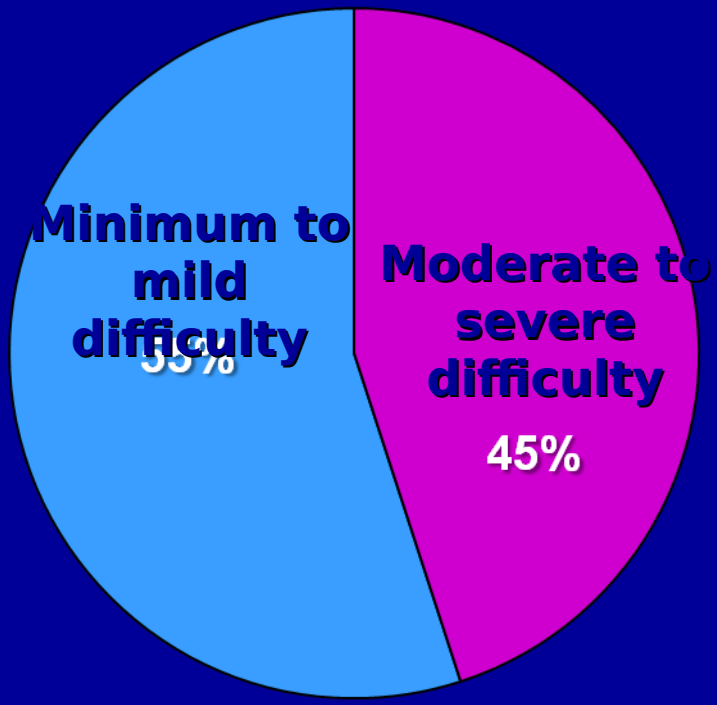
Developmentally appropriate language when communicating to children of different ages.

Must meet the needs of a family as they evolve and change over the course of hospitalization, recovery and reintegration.

Injury Communication Following Combat Injury

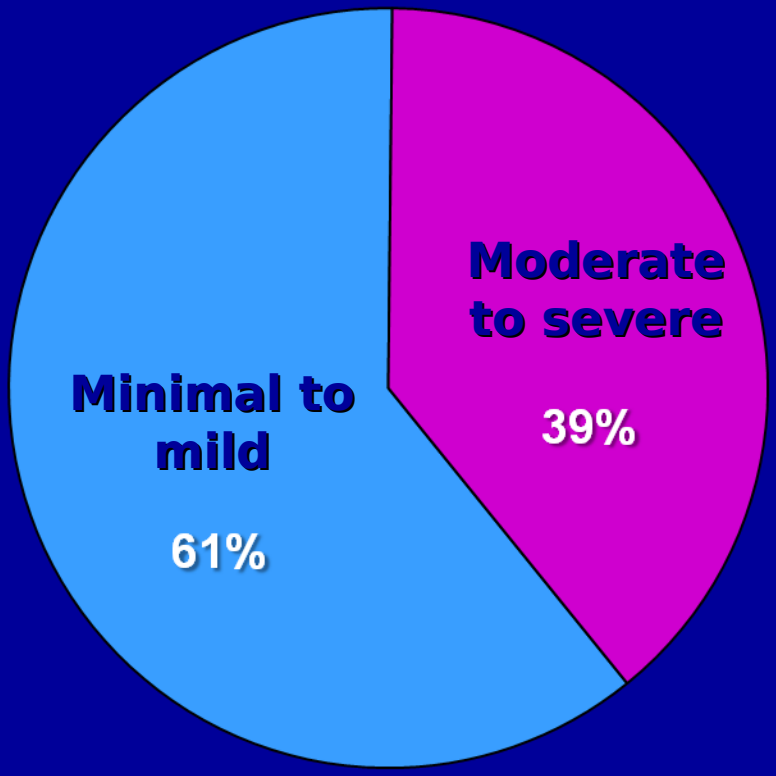
- 28% of families felt uncomfortable talking to children about injury
- 72% would like guidance in talking with children

SM's Ability to Relate to Spouse/Children Since Injury



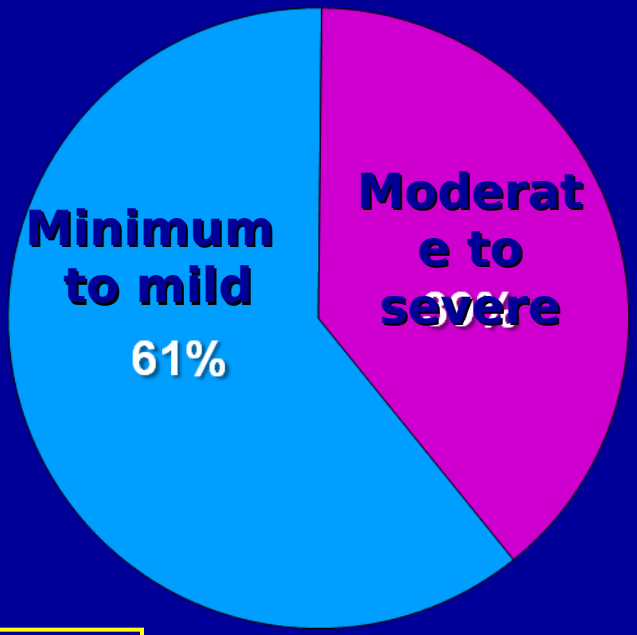
Scale: 1-5
Mean: 2.4
Std Dev: 1.3

Anticipated Changes in SM's Parental Role



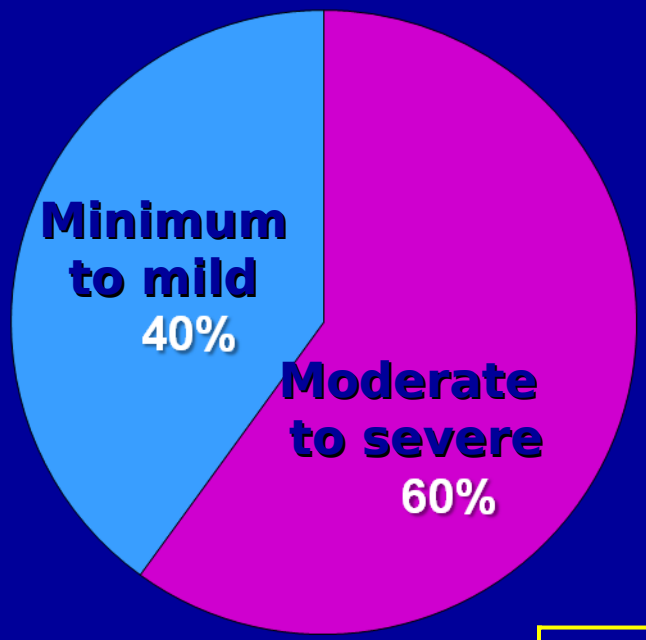
Impact on Children

Changes in Behavior



Scale: 1-5
Mean: 2.9
Std Dev: 1.4

Emotional Difficulty



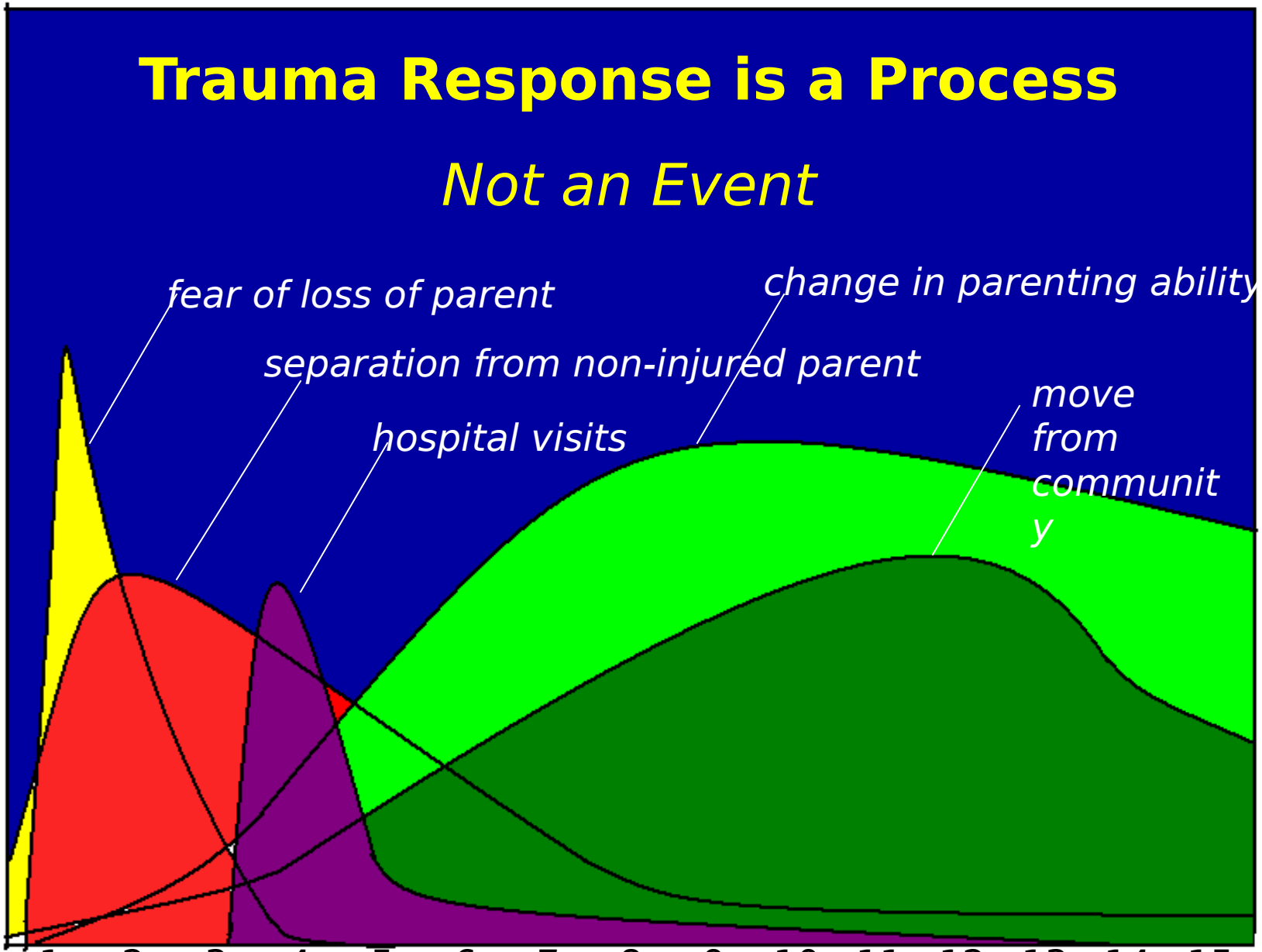
Scale: 1-5
Mean: 2.9
Std Dev: 1.4

PGA-CI Summary

- Young families with young children
- Severe injuries
- Multiple areas of disruption
  - Separation/living arrangements/time with child
  - Family/child schedule and discipline
- Guidance on injury communication is needed
- High impact on relationships, parenting, children
- Numerous stressors and sources of support

Trauma Response is a Process

Not an Event


fear of loss of parent
separation from non-injured parent
hospital visits
change in parenting ability
move from communit y
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
T I M E (months)

CHILD STRESS LEVEL

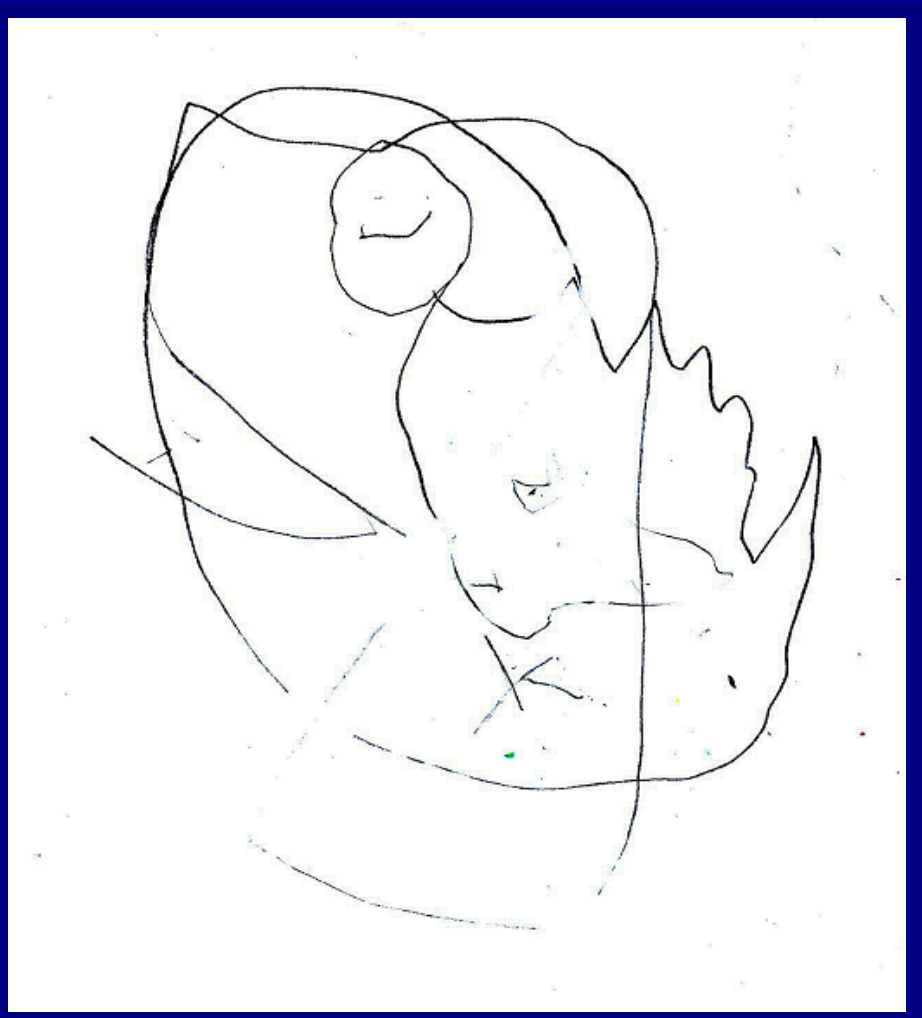
Impact of the Injury on the Parenting Process

- Need for mourning related to body change and/or functional loss
- Self concept of “idealized parent image” is challenged
- Must develop an integrated sense of “new self”
- Parental attention must be drawn to child’s developmental needs
- Explore new mutually directed activities and play (transitional space) that allows parent and child to “try on” new ways of relating

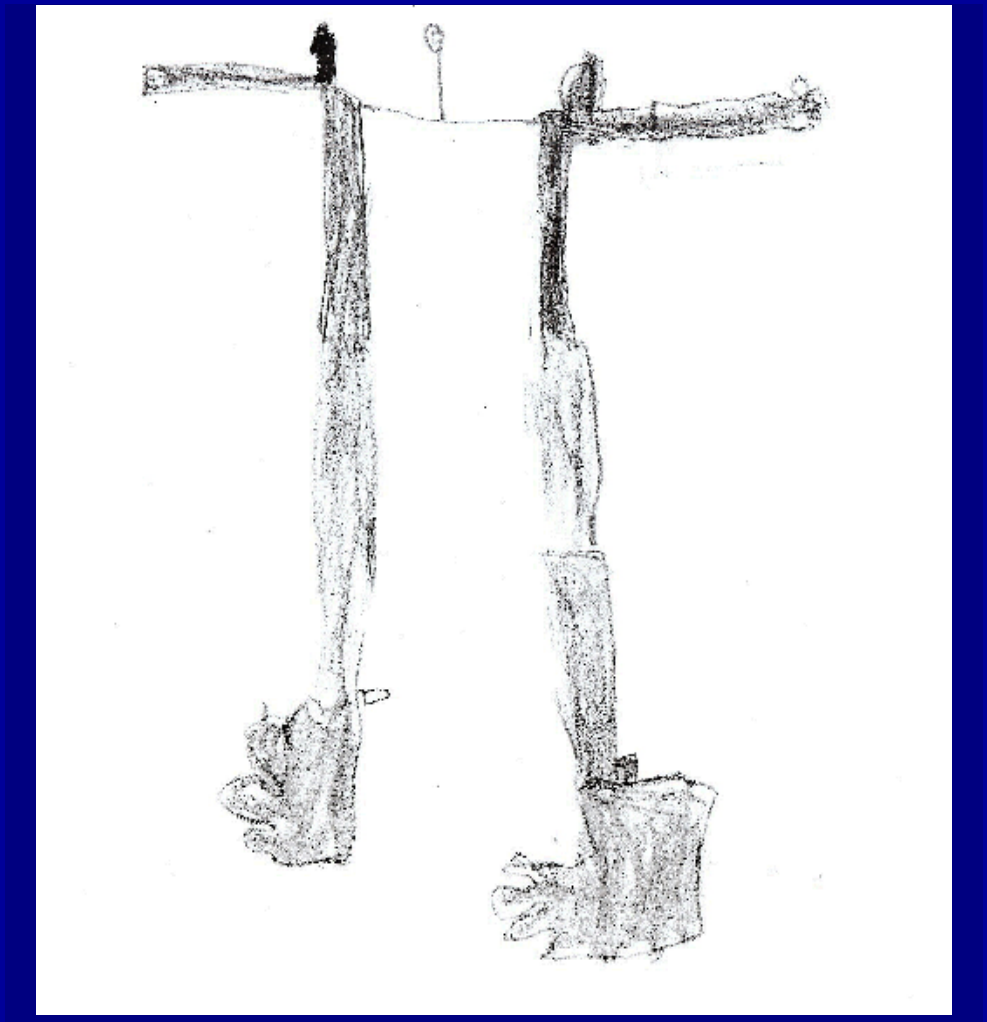
Impact of the Injury on the Child

- The meaning of the injury to the child
- Child's developmental limitations of understanding
- Time of parental distraction and preoccupation with injury
- Confusion about "invisible changes"
- Child must modify the internal image of his injured parent
- Health requires developing an integrated and reality based acceptance of parental changes

"Draw a Person" – 3 yo son of amputee



raw a Person" – 5 yo son of bilateral lower extremity ampute



UNIFORMED SERVICES UNIVERSITY
of the Health Sciences

Sesame Workshop
Coming Home

SESAME STREET

talk, listen, connect

Deployments, Homecomings, Changes

Treatment Facility Actions

- *Recognize the contributions of families as part of treatment and establish appropriate boundaries for involvement*

- *Develop child and family friendly treatment environments*
  - Welcome children and families
  - Families don't **VISIT**, they **PARTICIPATE** in care
  - Develop appropriate areas for family visiting
    - in room, on ward, off ward, dining area, family lounge
  - Develop child appropriate environments within the hospital
  - Ensure adequate available family lodging
  - Consider Child Life Worker involvement within the hospital

- *Protect children from unnecessary exposures*
  - Educate health care providers about child developmental issues and exposure risks
  - Develop a systematic methodology to prepare children for hospital visits
  - Support parents in parenting role and encourage them to speak with their children about health status

FOCUS-CI (Combat Injury)

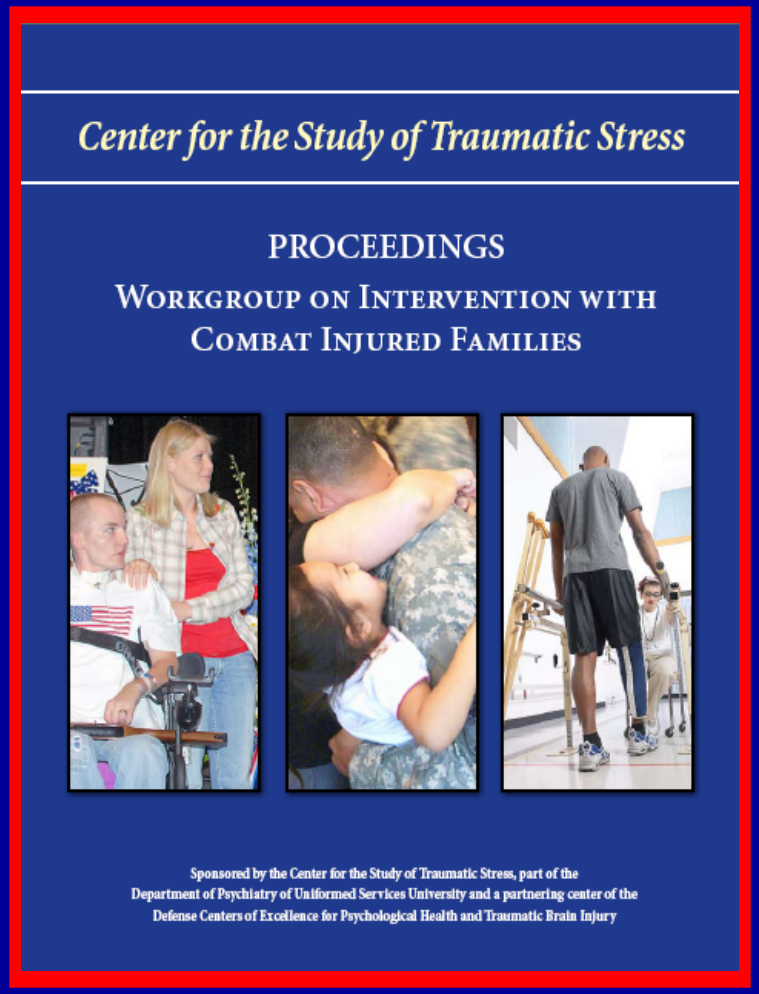
Congressionally Directed Medical Research Funded Study

Multisite study including WRAMC, BAMC, MAMC
Collaborators at UCLA, Harvard University, University of Washington

(Beardslee et al, 2007; Rotheram-Borus et al, 2004; Zatzick et al, 2001)

Developmental Tasks for Combat Injured Family Recovery

Workgroup on Combat Injured Families


Center for the Study of Traumatic Stress
PROCEEDINGS
Workgroup on Intervention with
Combat Injured Families
Sponsored by the Center for the Study of Traumatic Stress, part of the
Department of Psychiatry of Uniformed Services University and a partnering center of the
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

"The injury inherently disrupts the constellation and function of the family and adds stress to the family unit. It tends to widen splits in families that are already present, and add conflict when the dust has settled. Suddenly you have this injury event that just complicates things. Even when families pull together closely, the impact of the combat injury on families is more likely to disorganize than to organize families."

Children and combat death

- No reported studies examining combat deaths on U.S. children – some in development
- Israeli study examining difference between combat vs accidental injury in relatives (Bachar et al. 1997)
  - comparison of adolescents who lost relatives in war (n = 23) vs in roadside accidents (n = 19)
  - war bereaved showed significantly higher psychological well being and lower scores of psychiatric symptoms
  - no main effect for age was found
  - different meaning ascribed to death in battle vs. accident
  - limitations of study and generalizability

Children and combat parental death

- vulnerability in children as a result of parental death
- bereaved children more susceptible to PTSD than other populations of traumatized children (Pfefferbaum et al, 1999; Stoppelbein and Greening, 2000)
- combination of parental loss and other traumatic events results in more severe psychopathology (Pfefferbaum et al., 2002; Silverman et al., 2000)
- newer literature supports risks related to both bereavement and more so to childhood depression associated with parental death (Cerel, et al. 2006)
- ***childhood traumatic grief*** – unique consideration (Cohen, et al. 2002)

Parental Death in Military Families

- Family and child grieving
- Potential loss of military community support
- Probable family relocation
- Change of schools
- Services typically shift to the civilian community
- Early parental death is a known contributor to compromised child outcomes

FOR CHILDREN OF VALOR

Arlington National Cemetery

A Coordinated Effort

Military Population In Flux

Change of station between communities

Transition to civilian life

National Guard and Reserve units

Medical and psychiatric discharges

Know your role

Think about function across organizations

Sustaining Community Capacity

- Sustain resources that meet the needs of combat exposed families
  - *Sustain leadership and services*
  - *Sustain a sense of mission and meaning*
- Increase access to services
  - *Decrease barriers to include stigma*
  - *Identify those who are having difficulty*
  - *Encourage help seeking behaviors within the communities*
- Identify risk
- Educate to change attitudes and behaviors
- Coordinate and simplify agency efforts across military and civilian agencies

Tasks for Military Children when Parents Return from War

- Develop an age-appropriate understanding of what the parent went through and the reasons why
- Accept that they did not create the problems they now see in their families
- Learn to deal with the sadness, grief and anxiety related to parental injury, illness or death
- Accept that the parent who went to war may be “different” than the person who returned – but is still their parent
- Adjust to the “new family” situation by:
  - *staying hopeful*
  - *having fun*
  - *being positive about life*
  - *maintaining goals for the future*

Building a national community of care and concern for our military families

Center for the Study of Traumatic Stress
www.cstsonline.org
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